COLORADO
Department of Health Care Policy & Financing

Scheduled Date: ___/___/_____
Scheduled Time: ___: ___ ◯AM ◯ PM

Non-Emergent Medical Transportation Trip Report

Member Information:
Member's Name: _____ Member Health First Colorado ID #:_____

Did the Driver verify the member's identity? ◯Yes ◯No

Identity document: ☐Driver's License ☐Health First ID ☐Other

Member's Signature: _____ Date: _____

Driver/Vehicle Information:
Driver's Name: _____Vehicle Plate # or VIN #:_____

Type of Vehicle: ☐Ground Ambulance ☐Air/Rotor Ambulance ☐Wheelchair Van ☐Stretcher Van ☐Taxi ☐Mobility/Ambulatory Vehicle ☐Personal Vehicle ☐Public/Mass Transport ☐Commercial Air

Escort Name: _____

Trip Information: Type of Trip: ◯ ONE WAY ◯ ROUND TRIP

1. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer Drop-off Odometer Mileage

2. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer Drop-off Odometer Mileage

3. Actual Pick-up Time ◯AM ◯PM	Pick-up Street Address	City	State	Zip Code
Actual Drop-off Time ◯AM ◯PM	Drop-off Street Address	City	State	Zip Code

Pick-up Odometer: _____ **Drop-off Odometer:** _____

Certification:

Treatment Location/Medical Facility Name: Representative Name: _____

_____ Representative Title: _____

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Certifying Signature: _____